



February 7, 2012

**TO:** Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare & Medicaid Services

Deborah Taylor  
Director and Chief Financial Officer  
Office of Financial Management  
Centers for Medicare & Medicaid Services

**FROM:** /Brian P. Ritchie/  
Assistant Inspector General for the  
Centers for Medicare & Medicaid Services Audits

**SUBJECT:** Medicare Compliance Review of St. Vincent's Medical Center for Calendar Years 2009 and 2010 (A-01-11-00517) and Medicare Compliance Review of Riverside Methodist Hospital for Calendar Years 2008 Through 2010 (A-05-11-00058)

Attached, for your information, are advance copies of our final reports for two of our hospital compliance reviews. We will issue these reports to St. Vincent's Medical Center and Riverside Methodist Hospital within 5 business days.

These reports are part of a series of the Office of Inspector General's hospital compliance initiative, designed to review multiple issues concurrently at individual hospitals. These reviews of Medicare payments to hospitals examine selected claims for inpatient and outpatient services.

If you have any questions or comments about these reports, please do not hesitate to contact me at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@oig.hhs.gov), or your staff may contact the respective Regional Inspectors General for Audit Services:

St. Vincent's Medical Center

Michael J. Armstrong, Regional Inspector General for Audit Services, Region I  
(617) 565-2689, email – [Michael.Armstrong@oig.hhs.gov](mailto:Michael.Armstrong@oig.hhs.gov)

Riverside Methodist Hospital

Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V  
(312) 353-2618, email – [Sheri.Fulcher@oig.hhs.gov](mailto:Sheri.Fulcher@oig.hhs.gov)

Attachment

cc:  
Jacquelyn White, Director  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V  
233 North Michigan Avenue  
Suite 1360  
Chicago, IL 60601

February 9, 2012

Report Number: A-05-11-00058

Mr. Andrew S. Quinn, Esq.  
Senior Vice President & Chief Ethics and Compliance Officer  
Ohio Health Corporation  
180 East Broad Street, 30<sup>th</sup> Floor  
Columbus, OH 43215

Dear Mr. Quinn:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Compliance Review of Riverside Methodist Hospital for Calendar Years 2008 Through 2010*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through email at [Jaime.Saucedo@oig.hhs.gov](mailto:Jaime.Saucedo@oig.hhs.gov). Please refer to report number A-05-11-00058 in all correspondence.

Sincerely,

/Sheri L. Fulcher/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE  
REVIEW OF RIVERSIDE  
METHODIST HOSPITAL FOR  
CALENDAR YEARS 2008  
THROUGH 2010**



**Daniel R. Levinson  
Inspector General**

**February 2012  
A-05-11-00058**

# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Riverside Methodist Hospital (the Hospital) is a 1,059-bed acute care hospital located in Columbus, Ohio. Medicare paid the Hospital approximately \$549 million for 56,579 inpatient and 373,583 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

Our audit covered approximately \$1.9 million in Medicare payments to the Hospital for 104 inpatient and 62 outpatient claims that we identified as potentially at risk for billing errors. These 166 claims had dates of service in CYs 2008 through 2010.

### **OBJECTIVE**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

## **SUMMARY OF FINDINGS**

The Hospital complied with Medicare billing requirements for 142 of the 166 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 24 selected inpatient and outpatient claims, resulting in overpayments totaling \$107,070 for CYs 2008 through 2010. Specifically, 12 inpatient claims had billing errors, resulting in overpayments totaling \$67,929, and 12 outpatient claims had billing errors, resulting in overpayments totaling \$39,141. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$107,070, consisting of \$67,929 in overpayments for 12 incorrectly billed inpatient claims and \$39,141 in overpayments for 12 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that the largest number of mistakes detailed in our report involved previously identified OIG risk areas. The Hospital also stated that it is committed to ethical and compliant practices and will continue to address areas specified in the report where human error was the overriding cause of failure in existing controls. Finally, the Hospital stated that overpaid amounts have been corrected and resubmitted to the Medicare Administrative Contractor.

The Hospital's comments are included in their entirety as the Appendix.

## TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Hospital Inpatient Prospective Payment System .....	1
Hospital Outpatient Prospective Payment System.....	1
Hospital Payments at Risk for Incorrect Billing .....	2
Medicare Requirements for Hospital Claims and Payments .....	2
Riverside Methodist Hospital .....	3
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	3
Objective .....	3
Scope.....	3
Methodology .....	3
<b>FINDINGS AND RECOMMENDATIONS</b> .....	4
<b>BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS</b> .....	5
Inpatient Manufacturer Credits for Replaced Medical Devices .....	5
Inpatient Short Stays .....	5
Inpatient Transfers .....	5
<b>BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS</b> .....	6
Outpatient Manufacturer Credits for Replaced Medical Devices .....	6
Outpatient Dental Services .....	6
<b>RECOMMENDATIONS</b> .....	7
<b>HOSPITAL COMMENTS</b> .....	7
<b>APPENDIX</b>	
<b>HOSPITAL COMMENTS</b>	



## **INTRODUCTION**

### **BACKGROUND**

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.<sup>1</sup>

#### **Hospital Inpatient Prospective Payment System**

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

#### **Hospital Outpatient Prospective Payment System**

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.<sup>2</sup> The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.<sup>3</sup> All services and items within an APC group are comparable clinically and require comparable resources.

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

<sup>2</sup> In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

<sup>3</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

## **Hospital Payments at Risk for Incorrect Billing**

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments to hospitals reviewed by this and related audits included payments for claims billed for:

- inpatient same-day discharge and readmissions,
- inpatient short stays,
- inpatient claims billed with high severity level DRG codes,
- inpatient hospital-acquired conditions and present on admission indicator reporting,
- inpatient claims paid in excess of charges,
- inpatient psychiatric facility interrupted stays,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient dental services, and
- outpatient surgeries billed with units greater than one.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

## **Medicare Requirements for Hospital Claims and Payments**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” In addition, section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

## **Riverside Methodist Hospital**

Riverside Methodist Hospital (the Hospital) is a 1,059-bed acute care hospital located in Columbus, Ohio. Medicare paid the Hospital approximately \$549 million for 56,579 inpatient and 373,583 outpatient claims for services provided to beneficiaries during calendar years (CY) 2008 through 2010 based on CMS's National Claims History data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

### **Scope**

Our audit covered \$1,887,189 in Medicare payments to the Hospital for 166 claims that we judgmentally selected as potentially at risk for billing errors. These 166 claims had dates of service in CYs 2008 through 2010 and consisted of 104 inpatient and 62 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We based our review on selected billing requirements and did not use medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital during July and August 2011.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claims data from CMS's National Claims History file for CYs 2008 through 2010;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2008 through 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 166 claims (104 inpatient and 62 outpatient) for detailed review;
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by the Hospital to support the sampled claims;
- requested that the Hospital conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital complied with Medicare billing requirements for 142 of the 166 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for 24 selected inpatient and outpatient claims, resulting in overpayments totaling \$107,070 for CYs 2008 through 2010. Specifically, 12 inpatient claims had billing errors, resulting in overpayments totaling \$67,929, and 12 outpatient claims had billing errors, resulting in overpayments totaling \$39,141. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

## **BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 12 of the 104 sampled inpatient claims that we reviewed. These errors resulted in overpayments totaling \$67,929.

### **Inpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 412.89) require reductions in the inpatient prospective payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives a full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

The Manual, chapter 3, section 100.8 states that to correctly bill for a replacement device that was provided with a credit, the hospital must code its Medicare claims with a combination of condition code 49 or 50, along with value code “FD.”

For 8 of the 16 sampled claims, the Hospital received a reportable medical device credit for a replaced medical device from a manufacturer but did not adjust its inpatient claim with the proper value and condition codes to reduce payment as required. The Hospital stated that these errors occurred because, at the time the claims were billed, it did not have policies and procedures in place to report credits from the device manufacturers. As a result, the Hospital received overpayments of \$51,020.

### **Inpatient Short Stays**

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

For 3 of the 34 sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital attributed the patient admission errors to human error by the case management department. As a result, the Hospital received overpayments totaling \$9,946.<sup>4</sup>

### **Inpatient Transfers**

Federal regulations (42 CFR § 412.4(c)) state that a discharge of a hospital inpatient is considered a transfer when the patient’s discharge is assigned to one of the qualifying DRGs and the discharge is to a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. A hospital that transfers an inpatient under the above circumstances is paid a graduated per diem

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<sup>4</sup> The Hospital may bill Medicare Part B for a limited range of services related to some of these three incorrect Medicare Part A short-stay claims. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the MAC prior to the issuance of our report.

rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment that would have been paid if the patient had been discharged to another setting (42 CFR § 412.4(f)).

For the one sampled claim, the Hospital incorrectly billed Medicare for a patient discharge that should have been billed as a transfer. For this claim, the Hospital should have coded the discharge status to a home under a written plan of care for the provision of home health services, instead of as a discharge to home. Accordingly, the Hospital should have received the per diem payment instead of the full DRG payment. The Hospital stated that this error occurred due to a clerical error of inadvertently entering the appropriate patient status code into the wrong field on the Medicare claim form. As a result, the Hospital received an overpayment of \$6,963.

## **BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS**

The Hospital incorrectly billed Medicare for 12 of 62 sampled outpatient claims that we reviewed. These errors resulted in overpayments totaling \$39,141.

### **Outpatient Manufacturer Credits for Replaced Medical Devices**

Federal regulations (42 CFR § 419.45) require a reduction in the outpatient prospective payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual explain how a provider should report no-cost and reduced-cost devices under the OPPTS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

For 11 of the 30 sampled claims the Hospital received full credit from a device manufacturer but did not report the required "FB" modifier to reflect the credits received. The Hospital stated that these errors occurred because, at the time the claims were billed, it did not have policies and procedures in place to report credits from the device manufacturers. As a result, the Hospital received overpayments of \$38,673.

### **Outpatient Dental Services**

The Manual, chapter 1, section 80.3.2.2, states, "In order to be processed correctly and promptly, a bill must be completed accurately." In addition, chapter 4, section 20.4, of the Manual states, "The definition of service units ... is the number of times the service or procedure being reported was performed."

For one of two sampled claims, the Hospital incorrectly billed the number of units for an otherwise Medicare covered dental procedure. Specifically, the Hospital billed for the removal of two teeth even though it removed only one. The Hospital stated that this error occurred due to a clerical error. As a result, the Hospital received an overpayment of \$468.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare contractor \$107,070, consisting of \$67,929 in overpayments for 12 incorrectly billed inpatient claims and \$39,141 in overpayments for 12 incorrectly billed outpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

## **HOSPITAL COMMENTS**

In written comments on our draft report, the Hospital concurred with our recommendations. The Hospital stated that the largest number of mistakes detailed in our report involved previously identified OIG risk areas. The Hospital also stated that it is committed to ethical and compliant practices and will continue to address areas specified in the report where human error was the overriding cause of failure in existing controls. Finally, the Hospital stated that overpaid amounts have been corrected and resubmitted to the MAC.

The Hospital's comments are included in their entirety as the Appendix.

# APPENDIX





## APPENDIX: HOSPITAL COMMENTS

**Ethics and Compliance**

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614 | 544-4200  
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January 4, 2012

Sheri L. Fulcher  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region V  
233 North Michigan Avenue  
Suite 1360  
Chicago, IL 60601

**Re: Medicare Compliance Review of  
Riverside Methodist Hospital  
Report #A-05-11-00058**

Dear Ms. Fulcher,

Please accept this correspondence on behalf of Riverside Methodist Hospital (RMH) and OhioHealth, the not-for-profit parent corporation of RMH and a multitude of other hospitals and healthcare providers comprised of approximately 21,000 physicians, employees and volunteers throughout Ohio. The purpose of this communication is to comment, per your kind directive, on the above-entitled draft report and the OIG's findings and recommendations contained therein.

Before detailing RMH's concurrence with the findings and recommendations in the draft report, it is likely worth noting that, according to publicly available reports of similar OIG reviews throughout the United States, RMH appears to have the lowest Medicare overpayment amount to date. To be more specific, the OIG's audit spanned calendar years 2008, 2009 and 2010. The review entailed approximately \$1.9 million in Medicare payments encompassing 166 inpatient and outpatient encounters. Of the \$1.9 million, it is the OIG's recommendation that RMH refund \$67,929 for incorrectly billed inpatient encounters and \$39,141 related to inaccurately submitted outpatient claims. Although OhioHealth would clearly be desirous of having received an OIG audit report where no mistakes at RMH had been identified, the organization is pleased that continual efforts at ensuring the proper submission of claims in an arena of complex healthcare laws, rules and regulations were evidenced and affirmed during the OIG's review.

*Together we are a faith-based, not-for-profit family of leading healthcare providers:*

RIVERSIDE METHODIST HOSPITAL • GRANT MEDICAL CENTER • DOCTORS HOSPITAL • GRADY MEMORIAL HOSPITAL • DOCTORS HOSPITAL - NELSONVILLE  
HARDIN MEMORIAL HOSPITAL • MARION GENERAL HOSPITAL • HOMEREACH • OHIOHEALTH HEALTH CENTERS

As stated above, RMH and OhioHealth concur with the two OIG recommendations set forth in the draft report:

- Refund to the Medicare contractor \$107,070, consisting of \$67,929 in overpayments for 12 incorrectly billed inpatient claims and \$39,141 in overpayments for 12 incorrectly billed outpatient claims, and
- Strengthen controls to ensure full compliance with Medicare requirements.

However, OhioHealth and RMH would like to offer the following observation. In the OIG's draft report, it is stated that "Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims." Although technically correct for some of the calendar years analyzed, the overall conclusion does not necessarily reflect Herculean efforts undertaken by OhioHealth during portions of the final year of the OIG's review (2010). Efforts specifically related to inpatient and outpatient manufacturer credits for replaced medical devices, the issue that caused the majority of the itemized errors in the OIG's draft report.

In support of the preceding statement, it is noteworthy that the OIG's audit at RMH focused on ten known risk areas for historical noncompliance and heightened error rates at hospitals throughout the United States. Of the ten risk categories assessed by your staff at RMH, the OIG concluded that mistakes were made in the following areas:

- Inpatient and Outpatient Manufacturer Credits for Replaced Medical Devices
- Inpatient Short Stays
- Inpatient Transfers
- Outpatient Dental Services

Of the total 24 identified erroneous claims associated with the foregoing risk categories, 19, or 79%, involved manufacturer device credits. The remaining 5 mistaken submissions resulted from human error (e.g. clerical data entries) rather than, in our opinion, a lack of adequate internal controls.

While concurring with the OIG's findings and resulting recommendations, OhioHealth would like to note that the largest number of mistakes detailed in the draft report involved a risk area that had been previously identified by an OIG Probe Audit initiated by the Office of Inspector General's Office of Audit Services in Region I during 2010. In response to that earlier inquiry, OhioHealth took extraordinary steps to re-engineer the organization's entire process involving device credits. The enormous undertaking shed light on how difficult it is for providers to efficiently manage credits due to the need to coordinate two separate and distinct silos - patient accounts receivable and manufacturer/vendor accounts payable; the latter is clearly not under the control or direction of a provider.

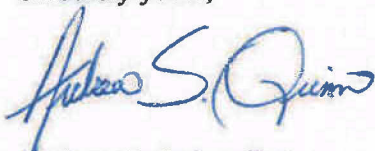
OhioHealth's response to the OIG Probe Audit resulted in enhanced communication protocols with device manufacturers. Deficient vendor communication was undoubtedly the leading cause of RMH's prior difficulties with the processing of credits since it is the manufacturer that controls a credit determination, not the provider. In any event, this rejuvenated process resulted in demands to all affected vendors to provide OhioHealth accurate and complete device credit reports. This directive, in turn, significantly improved the timeliness of credit issuances following device replacement procedures. The ensuing process, policies, procedures and audit requirements for assuring compliance in this most difficult area were, on more than one occasion, noted as commendable by your audit staff. As such, OhioHealth opines that, in the latter part of 2010, the third year of the review, it did have "adequate controls to prevent incorrect billing of Medicare Claims" specific to the first risk area above. A conclusion that should certainly be supported by your OAS staff, the Internal Controls Questionnaire submitted to the OIG, and numerous archival refunds reflecting OhioHealth's efforts in this area.

With regard to the OIG's recommendation to strengthen controls to ensure full compliance with Medicare requirements, please know that OhioHealth is unwavering in its commitment to ethical and compliant practices. The organization expends immense capital on maintaining an effective Compliance Program to assure both the proper submission of claims and an organizational culture of integrity. Furthermore, the system, via education, monitoring, auditing, Case Management Assignment Protocol (CMAP) implementation, constant updating of policies and procedures, and the utilization of all available technology applications, endlessly strives to comply with all legal and regulatory requirements. We will continue to do so going forward, especially in those areas specified in the draft report where human error was the overriding cause of failure in existing controls.

In closing, please be advised that all overpaid amounts detailed in the draft report have been corrected and resubmitted to the MAC. Also, I would be remiss if I did not acknowledge the professional and courteous nature of your audit staff during the review. RMH and OhioHealth are greatly appreciative of the guidance, patience and assistance offered by them throughout the course of their engagement.

Thanking you for the opportunity to provide these comments, and asking that you not hesitate to contact me if any further information is deemed necessary, I am,

Sincerely yours,

A handwritten signature in blue ink, appearing to read "Andrew S. Quinn". The signature is fluid and cursive, with the first name "Andrew" and last name "Quinn" clearly distinguishable.

Andrew S. Quinn, Esq.  
Senior Vice President  
Chief Ethics and Compliance Officer

cc: David P. Blom, President and Chief Executive Officer, OhioHealth  
Stephen E. Markovich, MD, President, Riverside Methodist Hospital